PROVIDER: _____ UNIT: _____ DATE: _____

RANK/GRADE: _____ Last 4 of SSN: _____ CATEGORY (circle): CG PHS CIV DOD AUX

REQUEST OF CLINICAL PRIVILEGES (CG-5575B)

DENTIST

REQUIRED PRIMARY CORE PRIVILEGES

DENTAL DIAGNOSIS AND MANAGEMENT: Provide initial and subsequent evaluations; establish working diagnosis, treatment, and case management per accepted treatment and management standards of care in the following General Dentistry conditions:

Alveoplasty	Dental radiographs	Non-surgical root canal therapy	Removable complete dentures
Amalgam and resin restorations	Diagnostic casts	Occlusal adjustment	Repair and rebase removable dentures
Athletic mouthguards	Diagnostic tests	Occlusal sealants	Replantation of avulsed tooth
Biopsy	Extraction, simple	Occlusal treatment appliances	Resin retained fixed partial dentures
Bleaching of vital/non-vital teeth	Gingival flap	Oral sedation	Scaling and root planing
Cast custom posts and cores	Gingivectomy/gingivoplasty	Overdentures	Space maintainers
Cast restorations	Hawley retainers	Preventive resin restorations	Stabilization of subluxated tooth
Ceramic/polymer restorations	Immediate dentures	Postmortem ID	Treatment planning
Dental examination	Implant maintenance	Provisional splint	Treatment of localized osteitis
Dental local anesthesia	Incision and drainage	Removable partial dentures	Treatment of simple traumatic wound
			Vital pulp therapy

PROVIDER: _____ UNIT: _____ DATE: _____

SUPPLEMENTAL PRIVILEGES

* SUPPLEMENTAL PRIVILEGES	DO	SDO	Recommendation	MLC	Recommendation	WKH	Recommendation
Active ortho appliances							
Adult dentition orthodontics							
Bone replacement graft							
Closed reduction of jaw dislocation							
Extraction, complete bony impaction							
Extraction, complicated							
Extraction, partial bony impaction							
Extraction, soft tissue impaction							
Free soft tissue graft							
Guided tissue regeneration							
Implant restoration(s)							
Interceptive orthodontics							
Limited orthodontics							
Molar uprighting							
Mucogingival surgery							
Osteoplasty/Ostectomy							
Subepithelial connective tissue graft							
Surgical root canal treatment							
Transitional dentition orthodontics							
Others: _____							
_____							
_____							
_____							
_____							
_____							
_____							
_____							
[ ] Check box if NO additional privileges required							
(Original Initials Required)	Requesting	Approval	Disapproval	Approval	Disapproval	Approved	Disapproved

**** Dental officers requesting supplemental clinical privileges will be required to submit additional documentation on training and education.***

PROVIDER: _____ UNIT: _____ DATE: _____

SENIOR DENTAL OFFICER'S ADDITIONAL RECOMMENDATIONS/RESTRICTIONS:

REVIEW AND SIGNATURES

DENTAL OFFICER REQUESTING
PRIVILEGES: _____ DATE: _____

SUPERVISING DENTIST: _____ DATE: _____

CHIEF, HEALTH SERVICES DIVISION: _____ DATE: _____

MAINTENANCE AND LOGISTICS COMMAND (K) : _____ DATE: _____
COMMENTS: _____
_____
_____
_____

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CHAIRPERSON, PROFESSIONAL REVIEW COMMITTEE

SIGNATURE: _____ DATE: _____

DIRECTOR OF HEALTH AND SAFETY

SIGNATURE: _____ DATE: _____